

## Voluntary Group Term Life and Dependent Life Insurance Enrollment/Change Form Employer Use Only

Employer use uniy												
Employee ID:												
Effective Date:												
Processed By:												
EMPLOYEE INSTRUCTION	<b>DNS:</b> Please (	complete ALL section	ns of this	enrollment	form and re	turn the	complet	ed forn	n to vo	ur Emplo	ver/Plan S	Sponsor
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Name of Employer/Plan Sponsor			•			count Number/Location						
Shelby County Government  Class/Occupation  Date of Hire (mm/dd/yyyy)			Id/mm/				01 – All Eligibles uployment				mo	
Olass/Occupation		Date of fille (filling)	u/yyyy)	Ailliuai S	aiai y	Stat	-	`   <del>-</del>	=	ve Part-T		
This change is due to	· (check all th	at annly)				Otat	uo.					Coverage
This change is due to: (check all that apply)  New Hire  Late Entrant*			*							tive Date of Coverage ange:		
Change in Coverage Amount Other:									0. 0	<b>5</b> 0.		
*A late entrant is an indivi		t annalling for supple	montal or	donondont	coverage of	tor the fi	iret availa	hlo onr	ortuni	hv		
A late entrant is an indivi	uuai wiio is iiis	t enrolling for supple	m <del>e</del> ntai oi	uepenuem	coverage an	ter trie ii	isi avalla	ible oht	JORLUIIII	ly.		
Employee Information												
Employee Name (last, fi	rst middle init	al)		1	Date of Birth (mm/dd/yyyy)   Social Security #					ritv #	Emplo	yee I.D.#
Employee Name (last, mst, middle initial)					Jato of Birtin			. 0000			yoo 1.D. 11	
Employee Address (stre	at addrace cit	v state zin code)			We	ne Number Hor		Home	ne Phone Number			
Lilipioyee Address (site	et auuress, cit	y, state, zip codej			***	ile indiiib	, Number Thome I home			vuilibei	Female	
												Male
					'							
Employee Life Insurance		(01) 1: -: 1: 0.1:		.11		. ( 00 = 0						
Basic Life	Guaranteed Issue (GI) Limit: 2 times annual salary to a maximum of \$350,000											
		Only										
Basic Life Insurance	N. Danimata		la									
Beneficiary Information  Name of Beneficiary (			IOW.	Drimon			Doloti	onship	to Em	nlovoo	Do	nefit %
name of beneficiary (	ast name, ms	, milatie initial)		Primary			Relati	onsnip	to EIII	pioyee	De	Helit /0
A d d u a a a					Data of	D:uth	Casia	al Casu	i.s N.I.		Dhan	a Niverala au
Address					Date of	Birth	Socia	al Secu	irity int	imber	Phon	e Number
Name of Beneficiary (last name, first, middle initial)				Primary		Relationsh			to Em	ployee	Benefit %	
Address					Date of	Birth	Socia	al Secu	ırity Nu	ımber	Phon	e Number
Name of Beneficiary (	last name, firs	t. middle initial)		Primary	ı		Relati	onship	to Em	plovee	Be	nefit %
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Address					Date of	Birth	Socia	al Secu	ırity Nu	ımber	Phon	e Number
Name of Beneficiary (	last name firsi	middle initial)		Contingen	t		Relati	onship	to Fm	nlovee	Be	nefit %
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Address					Date of	Rirth	Socia	al Secu	ırity Nı	ımher	Phon	e Number
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Name of Beneficiary (	last nama fira	middle initial		Contingen	<u> </u>		Dolo#:	onship	to Em	nloves	D <sub>2</sub>	nefit %
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A d dua a a					Detail	D:4l-	0	-1.0	udda a Kil		DI	a Nicosale
Address					Date of	חותו	2001	al Secu	irity NL	ımber	rnon	e Number
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Employee Life Insuran	ce									
Voluntary Life	Guaranteed Issue (GI) Limit = \$150,000. When you are first eligible for voluntary life coverage, you can elect up to the GI Limit without evidence of insurability. At all other times you must provide evidence of insurability subject to approval by ReliaStar Life Insurance Company, a member of the ING family of companies. Total voluntary life coverage up to \$400,000 is available if you complete an Evidence of Insurability form subject to approval by ReliaStar Life Insurance Company, a member of the ING family of companies.									
Voluntary Life Election	I am applying for voluntary life coverage in the amount of:   \$10,000									
Voluntary Life	ation Designate your honeficient/ice\ helevu									
	ation Designate your beneficiary(ies) below.  (last name, first, middle initial) Pr	imary Contingent	Relationship to Employee	Benefit %						
Address		Date of Birth	Social Security Number	Phone Number						
Name of Beneficiary (	(last name, first, middle initial)	imary	Relationship to Employee Benefit %							
Address		Date of Birth	Social Security Number	Phone Number						
Name of Beneficiary (	(last name, first, middle initial)	ontingent	Relationship to Employee	Benefit %						
Address		Date of Birth	Cooled Coought, Number	Phone Number						
Address		Date of Birth	Social Security Number	Phone Number						
Name of Beneficiary (	(last name, first, middle initial)	ontingent	Relationship to Employee	Benefit %						
Address		Date of Birth	Social Security Number	Phone Number						
Dependent Life Insurar										
Guaranteed Issue (GI) Limit = \$30,000 for your Spouse; \$15,000 for your Children. When you are initially eligible for dependent coverage, you can elect it without evidence of insurability. At all other times you must provide evidence of insurability on your spouse subject to approval by ReliaStar Life Insurance Company, a member of the ING family of companies. Eligible Children are those at birth but less than age 19; unmarried, full-time student dependents age 19 years but less than age 25.										
Dependent Life Election  I am applying for dependent life coverage in the amount of:  Option 1: \$20,000 Spouse/\$10,000 Child  Option 2: \$15,000 Spouse/\$7,500 Child  Option 3: \$10,000 Spouse/\$5,000 Child  Option 4: \$5,000 Spouse/\$5,000 Child  Option 5: \$25,000 Spouse/\$12,500 Child  Option 6: \$30,000 Spouse/\$15,000 Child  Cancel Coverage										
<ul> <li>READ THIS INFOR</li> <li>I authorize my emp</li> <li>To the best of my k</li> <li>I understand my co</li> <li>I also understand the Any person who, know any materially false in</li> </ul>	the beneficiary for any Dependent insurance cover MATION CAREFULLY AND THEN SIGN loyer to deduct from my wages the premium, if an nowledge and belief, the information I have provide verage begins on the effective date assigned by Finat evidence of insurability may be required for covingly and with intent to defraud any insurance of or control or conceals, for the purpose of nect, which is a crime, and may subject such per ture.	N AND DATE BELOV  By, for the elected coverage  ded on this form is correct.  ReliaStar Life, provided I a  verage to become effective  ce company or other pe  nisleading, information	e. m actively at work. e. rson files an application for concerning any fact mater	ial thereto commits a surance benefits.						
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